

Ethnicity, Social Status, and Families' Experiences of Caring for a Mentally Ill Family Member

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ABSTRACT: There is growing attention to the role of families as caregivers of family members with serious mental illness. This paper presents data from a multicultural sample of 90 family caregivers from diverse ethnic backgrounds. The paper examines families' experiences with mental health services; their support networks and family burdens; and their conceptions of mental illness. The paper both provides one of the first comparative studies of family caregivers from different ethnic groups and suggests an agenda for future research in this area.

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INTRODUCTION

It has been several decades since the beginning of the deinstitutionalization movement (Mechanic & Rochefort 1990). This movement began with the expectation that treatment for the mentally ill within the community would provide a greater chance for rehabilitation and reintegration (Warner 1986). However, today it is confronted with several pressing issues, such as the lack of adequate treatment programs in the community, and the lack of financial support for such treatment programs (Johnson 1990). This crisis within the mental health care system has affected all the parties involved: the communities, the mental health care system, the mentally ill individuals, and the mentally ill individuals' families. Today it is estimated that between one and two-thirds of patients discharged from mental hospitals return to live with their families (Goldman 1982; Lefley 1987b,c; Cook 1988). There has been an increase in research to assess the impact of the current mental health care situation on mentally ill individuals and their families (Hatfield 1987; Hatfield and Lefley 1987; Tessler et al. 1991; Jenkins 1988; Guarnaccia et al. 1992; Horwitz and Reinhard 1992; 1995; Tausig 1992; Tausig et al. 1992). Yet, there is a dearth of research on the impact that the current crisis in mental health care is having on minority populations. There is a pressing need for research into the special problems, needs, and circumstances that structure the experience of minority patients and their families in mental health treatment (Neighbors et al. 1982; Boyd-Franklin & Shenouda 1990).

One serious shortcoming in the literature is the lack of attention by researchers to the role of minority families in initiating and continuing treatment for the seriously mentally ill. Hatfield (1987) and Lefley (1989) have conducted research on family burden and stigma among European-American families with a mentally ill family member. These authors mention the lack of research with minority families and the importance of developing this perspective in the family literature. Lefley (1987c) reports that minority families view and cope with a mentally ill relative differently than European-American families. Existing research indicates that pathways into treatment are affected by the interpretations the family members place upon the patient's symptoms (Rogler et al. 1989; Rogler & Cortes 1993). However, few studies have explored processes of symptom interpretation and illness definition among minority families, whose cultural construction of mental illness often deviate quite radically from those of the majority and of professionals (Jenkins 1988, 1992; Guarnaccia et al. 1992).

There has been limited research in the U.S. on the particular burdens experienced by the families of minority patients whose coping capacities may be strained to the limit by scarce financial resources and fragmented community structures (Lefley 1990; Horwitz & Reinhard 1995). How such stressors affect the willingness and ability of families to provide support to patients in community treatment has been similarly neglected. Ethnicity and social class simultaneously affect contact with the mental health care system, levels of family support, and the social adjustment of ill individuals in the community. The family's cultural background and social class influence how the patient, the family, and mental health professionals perceive the illness and formulate the strategies required for managing it (Neighbors 1985; Boyd-Franklin & Shenouda 1990; Rogler & Cortes 1993).

This paper presents data from a study of families' conceptions of mental illness; their interaction with mental health care resources; and the burdens they experience in caring for an ill family member. The study is a comparative investigation of Hispanic-American (primarily Puerto Rican and Cuban), African-American (both African-American and West Indian), and European-American (primarily from Southern and Eastern Europe) families with a view to understanding the family's experience of caring for a seriously mentally ill family member and how the family's culture influences the recognition of symptoms, labeling of the illness, and responses to the family member's behavior.

DESCRIPTION OF THE STUDY AND THE SAMPLE

The data presented in this paper are from interviews with the main family care giver of seriously mentally ill individuals. The total sample for the study consisted of 90 families, of which 45 were Hispanic-American families, 29 African-American families and 16 European-American families. The families were identified through family groups and client populations of public community mental health centers and state psychiatric hospitals in the state of New Jersey. The sample consisted of individuals who had family members whose course of mental illness was prolonged and who required significant functional and emotional support from their families over an extended period. The relationship of the people interviewed to the mentally ill individual included parents, spouses, adult siblings, and adult children. For the most part, the psychiatric diagnoses of the ill individuals, as reported

by the families and the clinical staff, were either schizophrenia or bipolar disorder.

The study consisted of in-depth interviews with the family member who identified her/himself as being most involved in caring for the ill individual. The objective of these interviews was to determine how the family members responded to and coped with their relative's illness. The interview lasted approximately 1-1/2 hours and covered the family's overall experience with the mental health care system; conception of the problem; social support systems; and problems experienced as a result of having a seriously mentally ill family member. Interviews were tape-recorded, transcribed and then coded for computer analysis.

The families were recruited through referrals by program staff and direct contacts with family programs at 7 community mental health centers, 1 independent family group, and 1 state psychiatric hospital in New Jersey. The overwhelming majority of these families had used only public mental health care services. Community mental health centers were the primary focus of family recruitment because they had significant contact with minority families and because they had made an active effort to establish family groups. In addition, ethical considerations required that we work through established agencies to legitimize our contact with families and to protect families' confidentiality.

It is important to emphasize that this was an exploratory study and that the sample was an opportunistic one. Caution needs to be taken in generalizing from this sample to the larger groups reflected in it. In this report, we highlight areas of commonality and large difference among the ethnic groups involved. The findings should be viewed as issues to be explored in further research with larger samples of multicultural family caretakers from a wider range of areas.

RESULTS

Social Characteristics of the Families

Many of the primary caretakers of mentally ill family members were parents, and their main concern was what would happen to their family member when they were no longer able to take care of them. The issue of the aging of caregivers has become a national concern among advocates for families of the mentally ill (Lefley 1987a). The average age of caregivers by ethnic group was 48 for Hispanic-Americans, 54 for African-Americans and 55 for European-Americans. The average

age of the ill family members was 40, 34, and 35 years respectively. The younger age of the Hispanic caregivers and older age of ill family members is largely due to the unique presence of married couples among the Hispanics, where one spouse was the caregiver and the other the ill family member (see Table 1).

Mothers were the most frequent caregivers of ill family members. In 80 percent of the cases, the everyday care of the mentally ill family member was in the hands of a woman relative. The feminization of the care of any chronically mentally ill person is another central issue in caregiving research and policy (Cook 1988). In the case of people with serious mental illness, difficult burdens are reported, particularly when the woman caretaker is working and caring for other family members. These problems are made more severe when the woman caretaker is a single head of household. Further complications occur for female caregivers when the mentally ill family member is a son or brother who becomes aggressive or violent during periods of worsening of symptoms. These problems call for special support systems for these families.

Household income was calculated by aggregating all sources of earnings, including social security income and welfare benefits. Of the three groups, Hispanic-Americans were the poorest. Over 75% of Hispanics earned less than \$20,000 per year. This finding is particularly striking since the majority of Hispanic households had at least one employed member. Hispanic families were also most socially disadvantaged in terms of educational attainment of the caregiver. In our sample, almost 70 percent of the African-American families and 80 percent of the European-American families reported earning more than \$20,000. In spite of the range of incomes of families in our study, most families had been dependent on public mental health services and reported that limited incomes led to fewer choices of mental health services.

African-American family households were less likely than Hispanic-American or European-American households to contain both parents. Two thirds of the African-American households were headed by women, compared to one third of the Hispanic, and one quarter of the European-American households. European-American caregivers, often siblings of the ill family member, were the only caregivers to report that they lived alone. These findings indicate the need for other adult support people, either other family or friends, to assist the primary caregivers of mentally ill family members. While European-Americans have found these supports, to some extent, through family groups such

TABLE 1

Social Characteristics of Main Caregiver

<i>Social Characteristics</i>	<i>Hispanic</i>	<i>African American</i>	<i>European American</i>
<i>Age (Mean)</i>	48	54	55
<i>Gender</i>			
Female	80%	90%	87%
Male	20	10	13
<i>Relationship of Caregiver to Ill Member^c</i>			
Parents	42%	76%	75%
Sibling	13	21	19
Other	42	3	6
<i>Education^c</i>			
Less than high school	73%	21%	6%
High school or more	27	79	94
<i>Family Income^c</i>			
Less than \$19,999	78%	36%	20%
\$20,000 – 39,999	20	32	40
\$40,000 or more	2	32	40
<i>Household Composition^b</i>			
Dual Parent/extended family	67%	38%	69%
Female Head	33	62	31
<i>Living Arrangements^b</i>			
Living w/caregiver	78%	59%	31%
Living apart from caregiver	22	41	69
<i>Help Received by Ill Family Member (% Yes)</i>			
Personal grooming	43	44	27
Shopping & meals	66	46	40
Medical care ^c	64	36	8
Money Management	47	54	33
Social Support ^a	98	85	80
N=90	N=45	N=29	N=16
Chi-square	^a p<.05	^b p<.01	^c p<.001

as the Alliance for the Mentally Ill, minority families rely on informal networks of kith and kin and use formal family groups much less often. Other approaches to building supports for minority caretakers are needed.

Three quarters of Hispanic-American and 60 percent of African-American ill family members lived with the primary caregiver's family; while this was true in about one third of the European-American families. Ill individuals from European-American families either lived in residential programs or lived on their own in the community. These differences reflect both families' preferences for where their ill family member lived and the availability of residential programs to minority families.

Families reported a range of help that they provided to their ill family member. Families most frequently provided social and emotional support, such as being there to talk to and inviting their family member to social activities. Families also helped with meal preparation and shopping with food; helping their family member take their medications and keep clinic appointments; managing their money; and doing personal chores such as laundry and self care. Minority families tended to provide more instrumental help because their ill family members were more likely to live with them. Often families underestimated the kinds of things they did to help their ill family member, as they saw these as what family did for members still living in the household. Because the majority of the caregivers were women, many of the everyday tasks that were done for the ill family member were not seen as "work" but as part of the "normal woman's role" in the family. This finding both raises questions about conceptualizing caretaker assistance to ill family members as "burden" and methodological issues in measuring what demands are placed on caretakers (Greenberg et al. 1994).

Sources of Support for Caregivers and Family Burdens

Minority families tended to have social support networks that included more kin than those of European-American families (see Table 2). African-Americans and Hispanic-Americans sought out other family members for advice far more than European-Americans. European-American families turned to the mental health profession more than the minority families for advice. This seems to be related to the differences in their conception of their family member's illness. European-Americans saw the illness more as a medical problem, whereas minority families attributed the problem to a wider range of causes and

TABLE 2

Mental Health Services and Social Supports

	<i>Hispanic</i>	<i>African American</i>	<i>European American</i>			
SOCIAL SUPPORTS						
<i>Size of Network</i>						
1-2	21%	35%	36%			
3 or more	79	65	64			
<i>Sources of Support for Advice (% Yes)</i>						
Family	38	45	27			
Medical	27	17	33			
Other	13	28	27			
Nobody	16	3	20			
<i>Sources of Support for Concerns (% Yes)</i>						
Family	57	59	40			
Medical	2	3	0			
Other	25	34	40			
Nobody	16	3	20			
<i>Major Areas of Problems (percent yes)</i>						
Financial burden	52	62	64			
Physical/mental health ^a	52	52	93			
Family routine	74	59	87			
Social life	41	18	50			
MENTAL HEALTH SERVICES						
	First	Last	First	Last	First	Last
<i>Decision to Hospitalize (% Yes)</i>						
Family	47	57	42	70	47	53
Medical	44	29	27	5	20	13
Other	9	15	8	25	14	33
<i>Post-Hospitalization Services (% Yes)</i>						
Medication	88	96	78	95	86	83
Therapy	69	78	45	47	67	70
Residential ^b	0	0	13	17	29	67
Day treatment ^a	9	30	38	59	14	64
N=90	N=45		N=29		N=16	
Chi-square	^a p<.05	^b p<.01				

consequently sought advice from other areas. Two of the most striking findings were that none of the European-American families sought out religious advisors, and that Hispanic-Americans most frequently had no one to turn to for advice. This may be due to the lack of bi-lingual/cultural professionals available for the less acculturated Hispanic families.

All families turned to other family members when they needed to talk about general concerns or to ventilate their feelings about the burdens of caretaking. Few families turned to mental health professionals other than to talk with them about treatment advice. European-Americans and Hispanic-Americans had the highest percentage of no one to talk to when they needed to share their concerns about their ill family member.

All families saw disruption of family routine as problematic, as a result of the inconsistent behavior of their family member and the crisis that ensued. European-American families reported the greatest effects on their physical and mental health as a result of care taking; even though minority families were more likely to have direct contact with their ill family member. This may be due, in part, to the greater limitations of social support networks experienced by European-American families. European-Americans had somewhat smaller networks and fewer kinds of people to talk with for both advice and sharing concerns, resources which could enable them to vent and reduce stress as well as receive needed help at most stressful times (Horwitz & Reinhard 1995).

Families did not report financial burdens as a primary problem connected to their care-taking for an ill family member. Most of the ill family member's care was paid for by public funds. In addition, most of the ill family members received some form of income support. The income support was often a significant help in allowing families to continue to care for their ill family member. These social security programs including medical insurance and income support are vital to maintaining minority and low-income individuals in care and in the community. The financial burdens reported in Table 2 reflect limitations on earning supplemental income due to the time constraints of taking care of an ill family member; rather than direct financial problems caused by paying large amounts for their family member's care. Many families did express frustration that their choices of services and treatment options were limited by their lack of financial resources.

Many families did not see the care of their family member only as a "burden"; many families viewed caregiving as both rewarding and

stressful (Greenberg et al. 1994). For most of the family caregivers, tasks such as cooking, laundry, and managing money were seen as part of what you do for family. This was particularly true for the African-American and Hispanic families. Families did report the need for respite care to help when they felt overwhelmed or wanted to get away for a few hours or days.

Families' Experiences with the Mental Health Care System

Families described the first and most recent episode of their family member's illness and the process of deciding to hospitalize their family member. In both cases, the decision to hospitalize the ill family member was most often made by the family (see Table 2). In the first hospitalization, medical professionals and police played an active role in the hospitalization decision. The ill family member rarely made the decision that hospitalization was necessary. In the second hospitalization, both the family and the ill family member took more active roles in the decision-making process. Over time, from learning more about mental illness, from more experience in recognizing signs of worsening illness, and through more experience with the mental health care system, families developed more effective strategies for dealing with crises.

Across the three ethnic groups in this study, families were equally involved in the decision to hospitalize their ill family member. For Hispanic families, the hospitalization decision was made as often by a medical professional as by the family; this was much less true in the other two groups. In contrast, the police were more likely to be involved in the hospitalization of African-American and European-American ill family members.

In comparing ethnic group differences in the last hospitalization, different patterns emerge. We see the increase of family involvement across the ethnic groups, with the greatest rise in the involvement of African-American families. We see continued higher involvement of the medical system in the decision to hospitalize Hispanic individuals. This may be due to communication barriers which prevent Hispanic families from learning about more effective use of mental health resources. While the ill member has become more involved in the decision-making, this is most prominent in the European-American families. This may have to do with greater acceptance of the medical model leading to seeking help in mental health services and also may be influenced by the greater separation of ill individuals from the families among the European-Americans interviewed. While police are much

less involved, their involvement is now limited to the minority families where broader social stigmatization of different behavior is greater.

Many families, in discussing their experience with hospitalizing their family members, reported deep frustrations with the processes of commitment. Their own experience with and assessment of their family member was discounted by hospital staff and admission refused in spite of the families' feeling that significant deterioration had occurred. Their attempts to explain the context of their family member's illness and the clear signs of deterioration they noticed were not taken into consideration. The frustration many families expressed about getting family members help in a crisis was palpable during the interviews.

Services that ill family members received from the mental health care system fell into four broad categories: medications, therapy (either individual or group), residential programs, and day treatment programs (see Table 2). In all cases, more people were involved in various kinds of treatments after the most recent than after the first hospitalization. The overwhelming majority of ill family members received medications after both hospitalizations. Therapy was also quite common, although family caretakers were often not clear about the type and nature of therapy their family member was receiving. Residential programs were not widely used. This is due to several factors: minority families' preferences for having their ill family member with them; families' concerns about the quality of residential options; and at the time of the first hospitalization, lack of development of residential services. Day treatment programs increased markedly in use between the first and last hospitalization, often due to the increase in their availability.

Medication was the most widely used service after both hospitalizations. African-Americans received considerably less therapy than either Hispanics or European-Americans. While individual therapy is generally seen as less appropriate in seriously mentally ill individuals, this finding raises concerns about potential bias by mental health professionals about the effectiveness of therapeutic interventions with African-American individuals. By the most recent hospitalization, most European-American ill family members were in some sort of residential program; while a small percentage of African-American and no Hispanic family members used these services. While the minority families felt that at the present they preferred to have their ill family member living with them, the need for residential programs for minority individuals will increase with the aging of their caregivers. The low use of day treatment programs by Hispanics in contrast to

both African-Americans and European-Americans suggests that the lack of bilingual/bicultural day programs presents a significant barrier to use of these services by Hispanics.

Many families reported better connections with mental health services and more communication with program staff after the most recent hospitalization, especially when liaisons from the community mental health center worked with their family member prior to discharge. Families also expressed a need for crisis services where professionals would come into their home and help defuse a crisis.

Families generally reported considerable satisfaction with the services currently being used (Grella & Grusky 1989). They were particularly supportive of the various kinds of day treatment programs. They felt the opportunity for their family member to interact with others with similar problems, particularly after long periods of withdrawal and non-communication, was particularly beneficial. They appreciated assistance in getting their family member to take his/her medications. Most families were quite positive about the effect of medications on calming their family member and making them more stable, and would welcome suggestions on how to facilitate adherence to medication regimens. They felt particularly positive about vocational programs where their family member did real work and got some remuneration for it, albeit minimal. Limited availability of vocational programs was the major problem families faced in making use of these services.

Families' Conceptions of the Illness

Families were asked to describe the kind of problem they thought their family member had (see Table 3). The responses to this question were recoded into four categories. "Medical" responses included descriptions of the problem as a chemical imbalance or mental failure. "Emotional" responses focused on problems of nervousness; among the Hispanic families this was summarized in the cultural categories of *nervios* (Guarnaccia & Farias 1988; Jenkins 1988). Families who described their ill member's problem using personality descriptors like selfish or aggressive were placed in the "Personality" category. The final category was "Social" which included discussion of the problem in terms of interacting with others or problems in relationships. Hispanic families strongly felt that their relative was suffering from a problem that was more emotional than medical. European-Americans and African-Americans equally reported that they felt that their relative was suffering from a problem that was medical in nature; in both groups this was the

TABLE 3
**Conception and Label of the Illness by the Caregiver
 and Health Professionals**

<i>Conception of Illness</i>	<i>Hispanic (Percent)</i>	<i>African American (Percent)</i>	<i>European American (Percent)</i>
<i>Caregiver's Conception of the Illness^a</i>			
Medical	20	31	31
Emotional	40	28	31
Other	13	38	25
Don't know	27	3	13
<i>Professional's Label for Illness</i>			
Specific psychiatric diagnosis	44	64	81
General emotional/medical label	20	16	6
Don't know	36	20	13
<i>Agreement with Professional's Label^a</i>			
Agree	39	44	77
<i>Expectation of Cure^b</i>			
Yes	67	60	19
N=90	N=45	N=29	N=16
Chi-square	^a p<.05	^b p<.01	

most frequent response. African-American and European-American families were also more likely to report their family member's problem as stemming from negative personality traits than were Hispanic families. African-American families were most likely to report their family member's problem as one of social interactions.

Families were also asked what the professionals called their relative's problem. Schizophrenia was the most common response for all the families; particularly so for the European-American families. Over one-third of Hispanics and one-fifth of the African-American respondents did not know the diagnosis of their ill family member. This may well be an indication of differential education of families about mental illness. There are several possible explanations of these differences. For Hispanics, language barriers to obtaining information are

significant; although many of the Hispanic families were recruited through agencies with Spanish-speaking staff. Some minority families may not have been told the diagnosis at all; others may have been informed about the illness in a way that they did not retain the information. Another explanation would be that the professional's label did not match their own view of the illness and that saying "don't know" was a polite way of rejecting the professional model.

Clear differences emerged among the ethnic groups in the families' agreement with what the professionals called the problem; with minorities disagreeing much more than European-Americans. This lends further support to the hypothesis that some minority families actively rejected the professional model of mental illness. Three-quarters of the European-American families agreed with the professional's label of the illness; more strikingly none reported that they disagreed with the diagnosis. African-Americans reported more disagreement than Hispanics; while Hispanics more often responded that they did not know the diagnosis. This result may reflect greater distrust of professionals by African-Americans and a greater deference to authority by Hispanics (Boyd-Franklin 1990; Garcia-Preto 1982).

One of the most striking inter-ethnic differences was in the expectation of cure. Hispanics and African-Americans expressed a much stronger expectation that their family member's illness would be cured than did the European-Americans. This difference may result, in part, from the greater involvement with and effectiveness of psychoeducation approaches with European-American families (McFarlane 1983; Falloon et al. 1984). Strong religious beliefs in the healing power of God is another factor affecting these different perceptions; these beliefs were more strongly expressed by minority families. Further research on the different meanings of "cure" across groups and the role of optimism in caregiving are suggested by these results.

DISCUSSION

Implications for Future Research on Families

As discussed earlier, this study was designed to provide a profile of the experiences of families from different ethnic groups who were caregivers for a family member with mental illness. What clearly emerges from the results of the study are the central roles of culture, ethnicity, and social status in shaping families' experiences of caregiving. The study points to a number of areas where more focused research is needed to more fully understand the experiences of and determinants

of caregiving. With the continuing trend of downsizing and closing of state psychiatric hospitals, families will increasingly play a major role in the care of the seriously mentally ill. Given the over-representation of minorities in public mental health systems, a fuller understanding of minority families' experiences with both their ill family member and the mental health system are needed. We suggest several areas where more in-depth research is needed.

A central issue is differences both between and within ethnic groups of the definition of the family, its role in caretaking, and normative patterns of family growth and development. Our study suggests that Hispanics and African-Americans maintain closer family ties both with adult children and other relatives. This is by no means a new finding (see for example Stack 1974); but its implications for family caregiving for the seriously mentally ill are only beginning to be explored. Also, minority families are much more likely to expect unmarried family members to remain at home, regardless of their health, and to feel strong obligation and preference for caring for seriously ill family members at home.

Differing definitions and values placed on autonomy and independence by different ethnic groups play a key role in family responses to a mentally ill family member. The general approach of mental health professionals is to see client independence and autonomy as the ultimate goal. Much of the literature on family emotional environment focuses on the negative impacts of overinvolvement (Jenkins 1993). Across cultures, families differ markedly on values about family interconnectedness and involvement. Particularly in the case of serious mental illness, families from many cultural groups see it as the responsibility of the family to care for this individual and suggestions that the family should become less involved or that the ill individual should live outside the family home are viewed as challenges to the integrity of the family and insults to family loyalty. By incorporating more culturally diverse populations in family caretaking studies, researchers will both clarify the differing impacts of different levels of family involvement and re-conceptualize such concepts as over-involvement and autonomy.

A conceptual and methodological issue related to definitions of the family is the assessment of family burden. Much of the focus of recent research on families of the mentally ill has focused on burden and this has been an appropriate corrective to earlier views which blamed families for the mental illness of their family member. However, less attention has been paid to balancing research on burdens with examination of the rewards of caregiving and reciprocal aid between mentally ill individuals and their caregivers (who are often elderly adults). This

perspective has recently been put forward by Greenberg et al. (1994). In understanding issues of what leads caregivers to remain involved with their ill family member or to disconnect from them, this more balanced view may provide additional insights.

Further related to these issues are better methods for assessing social supports available to seriously mentally ill individuals and their families and more innovative ways to provide supports to multicultural families with a mentally ill family member. A particular area of social support research which needs further development is more processual studies of how different support networks affect access to information about mental health problems and services and determine access. From a programmatic point of view, there is a need for additional family support models to complement the very effective approach NAMI has developed among European-American families. While cross-cultural researchers have examined the role of social networks based on churches and other community supports; findings from these studies have neither become central to mental health services research nor to family program development.

In terms of access to services, there are several additional issues which emerge when minority families are included in studies. The issue of language barriers for Hispanic and other non-English speaking families looms large as a health services research issue. Language barriers affect access to information about mental illness and services to treat it; determine how effectively crises are reported and managed; structure the range of services available to clients and families; shape the diagnostic and therapeutic process; and determine the availability and suitability of post-hospitalization resources. Issues of discrimination and racism on the part of the system and individual providers also shape the clinical process—in our study, this issue was strongly suggested by the lower involvement of African-American individuals in therapy interventions and by the greater involvement of police in the hospitalizations of African-Americans.

Cultural issues also affect the accessibility and acceptability of a variety of services for the mentally ill. There is continuing controversy about whether minority clients in the mental health system should be served using different models of care or whether current models need to be better accommodated for minority individuals (Rodriguez, Lessinger & Guarnaccia 1992). One issue is the lack of developed models of culturally competent programs of day treatment, vocational rehabilitation, or family psychoeducation to compare to more standard programs (Rivera 1988). This is clearly a precursor to needed research on the relative effectiveness of accommodated versus ethnic group specific services for the seriously mentally ill.

Implications for Community Mental Health Services

An overwhelming majority of the families identified the following areas as major areas of need for help in caring for a seriously mentally ill family member. Vocational rehabilitation and training programs are a high priority for the majority of families for at least two reasons: (1) they provide structured activity which increases self-esteem and (2) they address some of families' concerns about the future of the ill family member. Family members express a need for more social contacts and activities (especially for weekends) for their ill family member where the ill individual can interact with peers who share similar problems. Several families also suggested some kind of companion program for their ill family member as potentially helpful. Families are concerned about the availability and quality of residential options for their family members. While there are marked differences among families of different cultural and social class backgrounds concerning where they feel their ill family member should live now, all families are concerned about housing options for the future. Family members want assistance with future planning, especially who will care for the ill family member when the current caregiver is no longer able to provide support and where the person will live.

Several respondents' own conception of their family member's problem was not shaped by the concept of schizophrenia. The extent of this divergence was most prominent among minority families. Religious belief and social class also played important roles in shaping families' conceptions of mental illness. This is an important area for more education. It is important to explore families' ideas about mental illness and to take their conceptions into consideration before schizophrenia and other forms of psychiatric disorder are explained. The need for multiple models of family psychoeducation sensitive to social and culture diversity is a critical imperative.

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